Potensial Limited

Heath Lodge

Inspection report

34 Green Lane
Padgate
Warrington
Cheshire
WA1 4JA

Tel: 01925816702
Website: www.potensial.co.uk

Date of inspection visit:
03 January 2018
04 January 2018
12 January 2018
31 January 2018

Date of publication:
17 October 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 3, 4, 12 and 31 January 2018. The first day was unannounced, the remaining days were announced. Heath Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contract6ual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Heath Lodge accommodates eight adults who have a learning disability and/or complex needs. At the time of the inspection the home was fully occupied. Five bedrooms were located in the main house with three annex buildings in the garden. The home is located in a residential area of Warrington, close to shops, other local facilities and is on the bus route to Warrington town centre.

During this inspection we identified significant breaches of the Health and Social Care Act Regulations with regard to regulations 9, 11, 12, 13, 16, 17, and 19. These related to concerns regarding consent; safe care and treatment; safeguarding people from abuse; person centred care, complaints and governance. The provider had also failed to submit relevant statutory notifications to the Commission. A notification is information about important events which the provider is required to tell us about by law. Failure to submit notifications is an offence under the Care Quality Commission (Registration) regulations.

We identified several instances where the registered manager had not notified the CQC as required with regard to safeguarding concerns and incidents reported to or investigated by the police. This meant that the registered manager had not complied with the legal obligations attached to their role.

Heath Lodge adhered to the provider's own internal quality assurance system. This included audits of areas such as care files, medication, finance and infection control. Although we could see that regular audits were being carried out, we had concerns about the effectiveness of them as they had failed to identify the issues and breaches of regulation noted during this inspection

We saw that the service had not always operated within the principles of the Mental Capacity Act 2005 particularly with regard to assessment of mental capacity and best interest decision making. Significant purchases had been made from service users' monies and we found several references to restrictive practice. The provider was unable to demonstrate that these decisions had been made in peoples' best interests. Records relating to management of service user finances were not sufficiently robust.

Although people told us that they felt safe at Heath Lodge, we found that safeguarding policies and procedures were not established and operated effectively to protect people from harm and abuse. Whistle-blowing concerns were received during the inspection. These included an allegation of aggressive and threatening behaviour by a member of staff towards a service user which had not been dealt with to ensure that the people living at Heath Lodge were protected from abuse and harm. We were also informed by the whistle-blower that the registered manager had instructed them not to inform the inspector of this incident.

We reported the whistle-blowing concerns to the local authority safeguarding team.

People's medicines were not managed or administered in a safe way. People did not always receive their medicines as prescribed, medical advice was not always sought when stocks were allowed to run out and we found that staff were instructed to sign Medicine Administration Records (MAR) retrospectively.

We asked people if they felt the staff were caring in attitude. Responses varied as some people said they were, however, one person felt they were spoken to with disrespect. We looked at daily living notes and found that the language used was at times disrespectful and inappropriate. During the inspection we observed staff speaking with people in a considerate way.

Recruitment procedures had not always been followed robustly to ensure that suitable people were employed.

People had access to external health professionals to support their health needs. However we found that referrals were not always made when required.

Responses varied as to whether care plans had regularly been discussed with the people living at Heath Lodge or that they had contributed to them. We found that care plans/risk assessments were not always sufficiently detailed or reflective of people's current needs. In addition monthly key-worker reviews were not always accurate or evidence that care plans had been reviewed.

People told us that they were happy with the food provided at Heath Lodge. We saw that people were regularly purchasing their own snacks and food items. We raised this matter with the nominated individual who informed us that they would be reviewing this to ensure that people's preferences were fully considered when weekly shopping orders were placed.

Staff were aware of people's dietary needs. A food safety and hygiene inspection was carried out by Warrington Borough Council in May 2017 and Heath Lodge was awarded a 5 star rating.

People were able to personalise their rooms and were able to choose how they spent their day. Details of advocacy services were available and we saw evidence that people had been supported to access this type of service.

The provider had a policy in place which included guidance for staff about infection prevention and control. Staff had access to personal protective equipment (gloves and aprons). Communal areas of the home were generally clean, tidy and had a homely atmosphere however some areas including paintwork and en-suite facilities required cleaning.

People living at Heath Lodge and staff told us there were enough staff to meet their needs, however that more staff were needed at weekends. Activities were provided but some people felt that there needed to be improvement in this area and said that one person could no longer attend the Friday Club due to lack of staff to support them.

We were told that a dependency tool was not used to determine staffing levels but that these were adjusted depending on service needs. We saw that staffing had been increased on the first day of inspection to support people for lunch at the local pub.

Values noted within Registering the Right Support and other best practice guidance include choice,

promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. We found that the service did promote independence and inclusion however that choice was not always respected.

Records were kept securely and were accessible to staff. We saw that service contracts and safety checks were completed as required for example, electric, gas safety, Legionella compliance and fire safety. People had a personal emergency evacuation plan (PEEP) detailing the support they would need in the event of any major incidents/emergencies.

At the time of the inspection there was no one receiving end of life care. We saw from care plans that some consideration had been given to this and where appropriate a do not attempt resuscitation (DNAR) instruction had been put in place.

The home had a registered manager in post who was present on the first two days of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We saw that there was a process for staff induction training, supervision and appraisal. Staff told us that they felt they had received the training they needed to carry out their job and that they felt the supervision and appraisal processes in place were worthwhile.

Immediately following the second day of inspection the provider put in place alternative arrangements for day to day management of Heath Lodge pending the outcome of an internal investigation. In addition alternative staffing arrangements were implemented in response to whistle-blowing allegations received by the inspector during and subsequently to the inspection visits. The nominated individual submitted an action plan and has provided on-going updates.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. You can see what action we have told the provider to take at the back of the report. We are currently considering our options in

relation to enforcement in relation to some breaches of regulations identified. We will update the section at the back of the inspection report once any enforcement work has concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Service users were not protected from abuse and harm by policies as policies and procedures were not established and operated effectively.

People did not always receive their medicines as prescribed and medicines were not administered or managed properly.

The provider did not always follow safe employment procedures.

Peoples' records were kept securely and were accessible to staff.

Is the service effective?

Inadequate

The service was not effective.

The service did not work within the principles of the Mental Capacity Act 2005 and we found evidence of restrictive practices.

People were not always supported to access external professionals to maintain their health needs.

People told us they could choose to eat and drink when and where they wanted to.

Staff, people using the service and families told us that the staff at Heath Lodge had received sufficient training to enable them to do their job.

Staff told us they felt the supervision, appraisal and team meeting processes were worthwhile.

Is the service caring?

Requires Improvement

The service was not always caring.

During the inspection we were made aware of allegations of abusive practice by staff. These were referred to the local authority and are subject to on-going investigation.

We saw that language used in documentation was sometimes disrespectful and people's continence needs were not managed effectively which compromised their dignity.

Staff were observed interacting with people living at Heath Lodge in a considerate and light-hearted way.

People were able to personalise their rooms and were able to access the community either independently or with staff support where needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and treatment that met their needs.

There was a complaints procedure, including a pictorial version, however learning was not taken forward to prevent recurrence and effective measures were not implemented to respond to this situation.

People felt that the staff knew how to care for them and what they needed.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had failed to submit notifications as required to inform the CQC about incidents or allegations of abuse and of incidents reported to or investigated by the police.

The providers quality assurance and audits systems were not sufficiently robust or effective to have identified the breaches of regulation and concerns identified during the inspection.

The registered manager did not mitigate identified risks to service users.

Staff said they felt supported and staff spoken with felt the manager was approachable and fair.

Heath Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was conducted over four days on 3, 4, 12 and 31 January 2018. The first day of the inspection was unannounced and was carried out by one adult social care (ASC) inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The remaining three days of the inspection were carried out by one ASC inspector.

Before the inspection we looked at information we held about the service and any notifications we had received. We liaised with the local authority and they shared their current knowledge about the home and told us that their last monitoring visit took place in November 2015. We checked to see whether a Health Watch visit had taken place and saw that one took place in November 2016. Health Watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. The report they produced gave a positive view from their visit.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with eight people who lived at the home and two relatives to seek their views. We spoke with the nominated individual, area manager, registered manager, deputy manager and five support staff. A nominated individual is a person who represents the provider and carries out the provider's role on their behalf. A nominated individual is responsible for supervising the regulated activity.

We looked at the care records of seven people who lived at the home, two staff recruitment files and inspected other documentation related to the day to day management of the service. These records included, staff rotas, training, induction and maintenance records. We requested additional information which was supplied electronically by the registered manager, nominated individual and area manager.

We toured the premises including bathrooms and with permission spoke with some people in their bedrooms and annex buildings.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe at Heath Lodge and found that people's responses varied. Comments included "Very safe", "Definitely yes" whilst others were "No" and "No, residents arguing here. I don't want to live with that. Worried someone attacks me". Relatives told us that they felt their family member was safe, "Yeah, he comes and goes when he pleases" and "Yes I do".

We saw that the provider had policies in place for safeguarding and whistle-blowing however we found that the policies and procedures were not established or operated effectively to protect people from harm and abuse.

We found that not all staff were able to demonstrate an understanding of safeguarding procedures. For example, we asked one member of staff what things they would report and they were unable to tell us without referring to the policy. This meant there was a risk they may not identify and report incidents of abuse. Although some staff said they felt able to report incidents and whistle-blow others said that they were fearful of losing their job if they did so.

We reviewed the safeguarding and incident records provided by the registered manager and additional records provided by the nominated individual following the inspection. We found several examples of concerns where safeguarding procedures were not followed which left people at risk of abuse and harm. There were examples of assaults between people using the service which had not been reported under safeguarding procedures, to the police or to the Care Quality Commission (CQC) by way of a statutory notification as legally required.

Towards the end of the second day of inspection a whistle-blower made the inspector aware of an alleged incident they had reported to the person in charge two days previously. This related to an allegation of aggressive and threatening behaviour by a member of staff towards a person using the service and we were told that such was the aggression that another member of staff had to intervene. In addition, we were told that the registered manager had instructed the whistle-blower not to tell the inspector about this incident.

Although this was reported to the person in charge and on call manager on 2 January 2018, the allegation had not been investigated or reported to the local authority safeguarding team and the member of staff involved had been present at Heath Lodge on 3 and 4 January 2018. The CQC had not been advised by submission of a statutory notification or directly to the on-site inspector despite the registered manager being asked by the inspector whether there were any other safeguarding incidents that they needed to be aware of. Following discussion with the inspector about this allegation the registered manager took action to remove the member of staff from the building pending investigation. We reported this information to the local authority safeguarding team and this incident is subject to on-going investigations.

We found there was a lack of robust recording of events, analysis of frequency or triggers to allow for appropriate protection planning for two people who had a history of incidents between them. This meant that a person using the service suffered on-going abuse and harassment.

These issues were a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems and processes were not established and operated effectively to prevent abuse of service users.

We asked people if they knew what they medicines they were taking were for. Comments included "Yeah", "Cream for hands, tablets at night, not sure what for" and "used to, now just take them".

Medicine administration records (MARs) sampled that were handwritten had been signed by two staff as required. We spoke with the deputy manager about medicine procedures within Heath Lodge and found that they were knowledgeable about systems and people's prescribed medicines. We saw that medicines were stored in locked cupboards. We checked the stock of two medicines and found these to be correct.

However, we found shortfalls in the safe administration of medicines and that people were not always receiving their medicines as prescribed. We saw that supplies of some medicines had run out however medical advice had not been sought or attempts made to obtain emergency prescriptions. We saw that a person regularly missed doses of pain relieving medicine; one person's pain relieving gel was out of stock from 1-10 December 2017 and one person was without a medicine for 3 days from 10-12 November 2017.

One person was prescribed a medicine which had a calming effect to be taken pro re nata (PRN) which means when required. We saw that this was administered regularly each night from 17 December 2017 until 6 January 2018. Staff sometimes recorded the reason for administration on the reverse of the MAR as "To help relax". However, when we reviewed the daily living notes for this person we saw that on the majority of days their mood was described in positive terms and there was no indication as to why this medicine would be required.

We saw no evidence that medical advice was sought regarding medicines not being administered as prescribed or that the GP had been made aware.

Information was recorded in a staff communication book. When we reviewed this book we saw numerous requests for staff to sign MAR charts retrospectively having failed to do so at the time of administration as required. This meant that these records were falsified and safe administration procedures had not been followed.

On 19 December 2017 a member of staff recorded on the reverse of a MAR chart that there was a discrepancy of 10 tablets. The count continued for the rest of the cycle evidencing that 10 tablets were missing however we saw no evidence of investigation or follow up regarding this missing medicine.

Staff responsible for administering medication completed accredited medication training and medication awareness e-learning. A matrix provided following the inspection noted that all staff had completed medication awareness e-learning in 2017. A competency assessment was also carried out every six months and we saw that some were currently being completed. However, the staff communication book contained entries stating that the registered manager had left medication theory tests in staff members' trays to complete and put back on his desk. As there was no supervision during completion of these tests this was not a reliable or safe way to assess staff's knowledge.

Some medicines should have the date of opening recorded to ensure that they remain safe to use however we sampled 2 medicines and found that the date of opening had not been recorded. Although a medication audit had been carried out on 31 December 2017 this had not been identified.

Medicine audits were carried out weekly and monthly the registered manager or senior support worker however these were not effective as they failed to identify any of the issues noted above.

These issues were a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment - safe and proper management of medicines.

We found that actions were not always taken to mitigate identified risks. We saw that that there was a risk that one person may smoke in their room. A care/risk plan noted that staff should carry out two hourly checks throughout the night documenting these checks on the electronic recording system used by the service, Caresys. We looked at daily living records from Caresys for this person covering 2 October 2017 to 31 December 2017 and could find no documented evidence of any checks having taken place.

This service user was prescribed a liquid paraffin based lotion and MAR charts indicated that this was applied three times daily. The NHS National Patient Safety Agency and government guidance has clearly identified an increased risk to people who smoke when using such products. However there was no specific risk assessment in place about this increased risk. The registered manager had reviewed and authorised care plans for this person but had failed to adequately identify and mitigate the associated risks.

We saw that an incident had occurred during which a person who was subject to an authorised Deprivation of Liberty Safeguard had returned unsupported from a family visit as a taxi had failed to arrive. They returned by bus and had become lost resulting in the police being notified. We asked a staff member about current arrangements for safe return transportation for this person and were informed that staff would either collect them using the company car or in a taxi. However, we saw from a record dated 7 December 2017 that this person had again returned by taxi unsupported by staff. We saw no evidence of investigation and care plans/risk assessments had not been updated to ensure that robust and safe arrangements were in place to support this person's return to Heath Lodge.

This was a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

We looked at how staff were recruited to ensure that those employed were suitable to work with vulnerable people and saw that recruitment procedures were not always safe. The provider had a policy in place about the process for Disclosure and Barring Service (DBS) checks. The DBS is a national agency that checks if a person has any criminal convictions to support safe recruitment decisions.

The provider's policy stated that if a DBS certificate contained details of cautions or warnings etc. the recruiting manager should complete a risk assessment to assess whether service users would be harmed if the person was employed. However, a risk assessment had not been completed for one individual despite the disclosure of significant information. The registered manager confirmed that they had not done so despite approving the person's employment. We saw that application forms were completed however noted that gaps in employment history were not always followed up.

These issues meant that people using the service were not appropriately protected by properly established and effective employment procedures.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, fit and proper persons employed.

The provider had a policy in place which provided guidance to staff about infection prevention and control.

We saw that staff had access to appropriate personal protection equipment (gloves and aprons) and that this was used appropriately. The registered manager had completed an infection control audit on 23 November 2017 which achieved a score of 100% in all areas. At the time of the inspection the communal areas of the home were generally clean, tidy and had a homely atmosphere although there were some areas including paintwork that that required cleaning.

We saw that people using the service were supported with cleaning their rooms however some were in need of additional cleaning, tidying or maintenance. One en-suite was malodourous and on 3 January 2018 we saw that a shower cubicle had mould around sealant areas and the window sill was stained. When we observed this cubicle again on 12 January 2018, the situation remained the same. On the first and second days of inspection we observed that one member of staff had long, pointed, painted fingernails which presented an infection prevention and control risk. The registered manager informed us that they had not noticed. We would recommend that the service undertakes a further infection control audit.

People told us there were enough staff to meet their needs although more were needed at weekend. We were told "Could do with 2 more staff at the weekends, usually 3 staff at the weekends", "Yeah, loads of staff" and "Oh yeah". A family member told us "(Name) used to go to the Friday Club, sometimes he can't go because of lack of staff, evening. Daytime no problems." Most of the staff we spoke with said they felt staffing levels were sufficient. Comments included "Yes, without a doubt" and "Yes, well staffed and a good team". However one staff raised the same issue about the person not attending the Friday Club due to insufficient staff. Therefore we would recommend that the provider reviews this situation.

At the time of the inspection there were eight people living at Heath Lodge. We discussed staffing levels with the registered manager and looked at staff rotas provided. We were informed that a formal dependency tool was not in use however that staffing levels were increased as and when needed to cover outings and for people who required support when accessing the community. We saw that staffing had been increased to support people using services to go to a local pub for a Christmas lunch.

We reviewed staff rotas and saw that the registered manager worked five shifts per week 07.00 – 15.00hrs which included some weekend cover; deputy manager cover was from 08-00 to 15.00hrs three days per week. We saw that a variety of shift patterns were evident for senior support and support workers. At night there was one staff plus one staff who slept on the premises and would be woken should support be needed.

People's records were kept securely and were accessible to staff. We were provided with evidence that service contracts and safety checks were completed as requested for example, electric, gas safety, Legionella compliance and fire safety.

We saw that people had a personal emergency evacuation plan (PEEP) detailing the support they would need in the event of any major incidents/emergencies.

Inadequate

Is the service effective?

Our findings

People told us that they felt the staff were sufficiently trained to meet their needs. Comments included "Yeah", "Yes" and "I think they are very qualified".

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this was in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

At the time of the inspection two people living at Heath Lodge had authorised Deprivation of Liberty Safeguards in place. The provider should inform the CQC by submission of a statutory notification when they know the outcome of an application to deprive someone of their liberty however, the provider had failed to do so on both occasions.

When reviewing the daily living entries we found several examples of restrictive practice. We saw that a person was being refused food items and that this caused the person distress. Examples included records made by staff which stated "I explained that I don't think it is appropriate to give these items to him …… offered him some cheese on toast and then only afterwards could he have some biscuits", the person said they felt like they lived in "a jail house" and "can't eat anything"; the person was shouting and swearing at staff as they had been told "it was too early for biscuits, he needs to have his breakfast before biscuits" and "Asked staff if he could have biscuits straight after breakfast , staff said later on it is too early to be eating biscuits, (Name) got upset".

The registered manager had implemented a care plan noting that limitations should be placed on the type of food this person ate however, there was no evidence of completion of a mental capacity assessment or best interest decision made and they failed to identify the manner in which this instruction was then carried out or the impact this was having. Records also indicated that this person had got up in the night and asked for their tobacco at 03.00hrs but was told it was too early and that they could have it at 06.00 hrs.

An incident report noted that a person was "held" by a member of staff during an altercation between people using the service. There was no evidence that this reference to physical restraint had been further investigated.

We saw that significant purchases had been made for people who lacked capacity to make those decisions themselves. These included the purchase of bedroom furniture, although rooms were provided on a furnished basis, and holidays including a trip abroad with a service user at a cost of over £4,000. We asked the provider for evidence of mental capacity assessment and best interest decision making around those

transactions and they were unable to provide such evidence.

Cash record sheets were maintained for each service user. We saw that some items which would ordinarily be supplied by the service had been purchased from service user's monies. For example, quilts, pillows, and food items. This was brought to the attention of the nominated individual and we were informed a financial audit had been arranged. They were also arranging for a review of the documentation used to record mental capacity assessments and best interest decisions.

These issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, consent as staff did not act within the principles of the Mental Capacity Act 2005.

We saw that people had access to visits from the doctor and that people were supported to attend appointments to maintain their health needs. One family member told us "If he is bad he can see his doctor". However we found that this this did not always happen and that referrals to relevant professionals were not always made.

For example, we saw that a person had been complaining of toothache but had not seen the dentist. We saw from daily living entries that one person had been incontinent of urine/faeces on numerous occasions and, although staff had purchased continence products on this person's behalf, a referral had not been made for assessment by the continence service. In addition, we saw that although this person's care plans had regularly been reviewed the plan in place for continence did not accurately reflect their needs, the support they required, or that continence products were being purchased. As noted in the Safe section of this report we found that medical advice was not always sought when people did not receive their medicines as prescribed.

These issues meant that people were not always supported to access professionals to ensure that their health needs were met.

This was a breach of regulation 9 of the Health 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care.

People told us that there was a choice of foods available and that they could choose to eat and drink were and when they wanted. One person who lived in an annex told us that "Sometimes I cook and take the food over to the house to eat with them" and a family member said "Staff are very good like that". When we asked people what they thought the staff did well, one person told us "the food".

We visited the kitchen and found it to be clean and tidy. We saw that people could make their own drinks when they wanted and that staff were available to support those who needed help. We were provided with menus covering a four week period. These evidenced that the lunchtime meal was usually sandwiches or soup with the main meal of the day served at tea time. The menus noted one main option each meal time with alternatives or preferences noted on some but not all days. For example, individual's preference of soup variety, that some preferred tomatoes or cheese on toast rather than beans and boiled rather than diced potatoes. Staff were aware that one person required a pureed diet. A food safety and hygiene inspection was carried out by Warrington Borough Council in May 2017 and Heath Lodge was awarded a 5 star rating.

We saw that people regularly purchased their own snacks and the nominated individual advised they would be reviewing this to ensure that people's preferences were fully considered when placing weekly shopping orders.

People's weights were recorded each month and a Malnutrition Universal Screening Tool (MUST) completed to monitor for risk of weight loss. This information was held on Caresys and reviewed by the registered manager.

Staff spoken with told us that they felt they had received the training they needed and that they received regular supervision and appraisal. Comments included "Training is very good", "I feel able to ask and would get additional training" and training is "Second to none". People also told us that they felt staff were sufficiently trained.

We asked the manager for records relating to the supervision, appraisal and training of staff. The training matrix provided by the registered manager evidenced that staff had received a wide range of training which included both mandatory e-learning such as fire awareness, infection prevention and control and safeguarding and service specific training such as positive behaviour support and acquired brain injury. The supervision schedule provided evidenced that regular supervision had taken place, staff spoken with told us that they felt that the supervision, appraisal and team meeting processes in place were worthwhile. Comments included "Yes, good feedback" and "Yes, absolutely a worthwhile process".

New staff completed an induction programme usually lasting three months with progress recorded in a booklet. We looked at the induction booklet for a member of staff who commenced employment on 2 November 2017. We saw that the first day of service page had been completed and signed off on 28 November 2017, however, the remainder of the booklet week 1, 2, 3 and one month was blank as were the 7 assessments section. We recommend that the provider reviews staff induction programmes to ensure that they have been fully completed.

Requires Improvement

Is the service caring?

Our findings

People told us that they thought the staff were caring. Their comments included "Very much so", "Yeah, definitely, most of them", however one person told us "No. Sometimes they speak to me with disrespect – tone". Relatives said they found the staff to be caring, comments included "Yes, quite pleasant" and "Very much so. I have a great deal of respect for the staff. A lot of them really go the extra mile."

During and following the inspection we were made aware of allegations of abusive practice by members of staff. We referred those allegations to the local authority safeguarding team and they are subject to on-going investigation.

We looked at entries in the daily living notes and we found that the language used was at times disrespectful and inappropriate. For example, "(Name) had wet the bed again", "(Name) was moody this morning", "(Name) quite demanding today", "Was asked to go for a pee but said he didn't want one" and "(Name) has been very demanding today".

From records reviewed we saw that people's continence needs were not being managed effectively compromising their dignity.

Relationships between people who lived at Heath Lodge were at times fraught and in one case had become a long standing issue leaving one person the victim of ongoing abuse and harassment as detailed in the Safe section of this report. However, we saw that where possible, people were supported to maintain family relationships. Some people told us that they felt staff listened to what they had to say, their comments included "Yeah, very much so" whilst others said "Sometimes" and "Not all the time".

During the inspection we observed staff speaking with people in a considerate way and some light-hearted interactions. Interactions did not appear rushed. It was clear that the manager and staff knew people well. Staff knocked on people's doors, introduced themselves and asked if they could go in before entering. People were able to lock their rooms if they chose to. Staff, including the registered manager told us that they would be happy for a relative of theirs to receive care from the service telling us "Because I know staff team go above and beyond", "It promotes small intimate care, no-one sits in the background. I think it is a really good thing".

People told us that they received their mail and opened it privately. Relatives told us that staff had never spoken about personal information relating to their relative in front of others. However, we saw that daily living entries included details of other service users who were referenced by initials or name so were easily identifiable. We recommend that unique identifiers are used for each individual in order to maintain confidentiality and privacy.

People were able to personalise their own rooms. Some people were able to access the local community for shopping trips independently whilst staff provided support to those who needed it.

Details of advocacy services were available and we saw evidence that people had been supported to access this type of service.

Requires Improvement

Is the service responsive?

Our findings

People told us that they felt the staff knew how to care for them and what they needed. Their comments included "Yes, very much so. Tomorrow they will help me to clean my room and wash my beddings and clothes." Yes, everything. Take me out shopping, clean my room" and "Yeah, Yeah". One relative told us that they felt the care received was "Probably towards very good" whilst another described it as "OK".

People were aware of their care plans but responses varied as to whether they had regularly discussed or contributed to them. Comments included "Yeah, signed a copy of it", "Review every two months" whilst others said "No, they do now and again" and "No, I think so". We also asked family members if they were involved in their relatives care if appropriate, and were told "Not lately, used to, a long time ago" and "Sometimes, not very often".

We looked at people's care records and found that these contained some person-centred information about people's likes, dislikes and associated risks. Positive behavioural support plans were also implemented to support people with regard to particular conditions or behaviours. However, we found that care plans/risk assessments were not always sufficiently detailed and reflective of people's current needs. For example, we saw that two people regularly experienced episodes of incontinence however the care plans in place did not accurately reflect their needs or support required and referrals for assessment or review by the continence service had not been made. Following the inspection we discussed this with the nominated individual who advised that they would arrange for referrals to be made.

We saw that where people experienced behaviour that challenged there was a lack of collated evidence to sufficiently identify themes, triggers and strategies to inform care planning. This meant that there were ongoing conflicts and incidents which were not adequately reflected in care plans or risk assessments.

We saw from care files that a key worker system was in place and that each month the key worker carried out a review. This review included review of 1:1 hours; use of PRN medication; incidents review of outcomes of care plans and risk assessments; activities and room check. There was evidence that the reviews included meetings with the people using the service. This form was then reviewed by management to allow care plans to be updated.

However, we noticed that the section to confirm that care plans had been reviewed was not always completed and this had not always been identified during management checks. In addition people's comments did not support that a monthly review of their care plans was taking place. Therefore, although there was evidence that some discussion had taken place with the service user, care plans had not always been regularly reviewed by the key worker as required. We also saw that reviews undertaken by the registered manager were not always reflective of current needs or the support that the person required.

In addition, we found that these were not always accurately completed. For example, one form for October 2017 noted that no PRN medication had been administered whereas the MAR charts noted that a PRN medication had been administered each night from 16 to 25 October.

These examples did not demonstrate that people's needs were appropriately assessed and reviewed so that person centred care could be provided.

These issues were further breaches of regulation 9 of the Health 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care.

The provider had a policy in place to record complaints and people told us that they knew how to raise concerns if they were not happy. Their comments included "Take it to [Name]" and "I go and see my care worker or the boss". One person told us that they did not know how to raise a concern. A pictorial complaint leaflet was also available.

We were provided with the complaint file and noted the last complaint was recorded in April 2016. This related to allegations of ongoing verbal abuse from one person living at Heath Lodge towards another and therefore should have been investigated via safeguarding procedures. We found that there were numerous further references in daily records of similar incidents which demonstrated that lessons had not been learned or effective measures implemented to respond to this situation.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, complaints.

The registered manager was knowledgeable about the people living at Heath Lodge in terms of their individual history and interests. Some people were able to access the community independently whilst others required support from staff. One person enjoyed walking on familiar routes and was out doing so most days. The registered manager told us that this person had made friends and was well respected in the local community. However, we found that there were occasions that one person was prevented from accessing the community due to there being insufficient staff on shift to support them as detailed in the Safe section of this report.

People were able to choose how they spent their day. We saw that some people were up and about quite early whilst others chose to stay in bed longer. Care records noted one to one support was provided although the majority of these sessions were recorded as conversations or chats.

We asked about activities and some people told us that they went out most days independently adding "I do my own activities, I do rugby, go to see my (relative) and I go and do a bit of punting and betting". Other comments included "There are activities available, not sure what" and "Just TV, a video or DVD. I just go out every day in town". We saw that people were supported to take holidays however, as noted in the Effective section of this report we identified concerns with regard to the planning and decision making for these trips. One relative told us that there was a darts board, and another said "They do go out one or two trips a year. I think they should make a lot more efforts to provide activities" and "He seems to be doing nothing up there". We recommend that the provider reviews the activity programme for Heath Lodge.

At the time of our inspection there was no one receiving end of life care. We saw from care plans that some consideration had been given to this and where appropriate a do not attempt resuscitation (DNAR) had been put in place.

We asked people what they thought staff did well and were told "I think the staff do everything well", "Cooking the meals" and "They try to go out of their way to please you".

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post who was present on the first two days of the inspection. We asked people who used the service if they felt the service provided at Heath Lodge was well led. All people spoken with responded positively telling us that they thought that it was.

The registered manager is required to notify the Care Quality Commission (CQC) of certain events that may occur in Heath Lodge. We identified several instances where the registered manager had not notified the CQC as required with regard to safeguarding concerns and incidents reported to or investigated by the police. This meant that the registered manager had not complied with the legal obligations attached to their role.

This is an offence under Regulation 18 (1) (e) and (f) of the Care Quality Commission (Registration) Regulations 2009 in that, the registered person had failed to notify the CQC without delay of any incidents of abuse or allegations of abuse in relation to a service user or incidents reported to, or investigated by the police. We will report on any further action in respect of this once it is completed.

As noted in the Safe section of this report we found that safeguarding procedures were not established and operated effectively. On the second day of the inspection we received information from a whistle-blower about an incident that was alleged to have taken place prior to the inspection. We were told that on 4 January 2018 the registered manager had instructed the whistle-blower not to inform the inspector about this incident. We then asked the registered manager if there were any other safeguarding concerns we should be aware of and were told there were none. The registered manager failed to investigate or manage this allegation effectively, and did not demonstrate effective management or leadership to staff, which meant that people were left at risk abuse or harm.

Health Lodge adhered to the provider's own internal quality assurance system. This included audits of areas such as care files, medication, finance and infection control. Audits were carried out by the registered manager and a quality audit was carried out by the area manager who visited usually monthly. In addition, the registered manager told us that an area manager from another area and home managers carry out cross checks. Although we could see that regular audits were being carried out, we had concerns about the effectiveness of them.

Despite a range of auditing and monitoring systems being in place, it was evident that they were not sufficiently robust to have identified the concerns and breaches of regulation highlighted during the inspection. For example, during our inspection we identified breaches of regulation relating to: person centred care; safe care and treatment; failure to notify the CQC of incidents of abuse or allegations of abuse and incidents reported to or investigated by the police; failure to act within the principles of the Mental Capacity Act 2005 and governance. Audits failed to identify the issues noted during the inspection for example finance, medication and the area manager monthly audits.

In a care plan entitled "Lone Working", we saw reference to a fire risk as one person was known to smoke in

their room and an instruction was recorded by the registered manager that staff must make two hourly safety checks during the night and record them on Caresys. This information was not reflected in a specific fire safety risk assessment and there was no consideration to daytime safety. The registered manager had carried out care plan reviews, and the area manager noted an increased fire risk after finding the person smoking in their room during her monthly audit. However, neither had identified that the risk assessments were not sufficiently robust or that there was no evidence of the required safety checks taking place. There was also an additional risk to this person due to the use of a paraffin based emollient which had not been identified. We advised the nominated individual of our concerns in this regard and they took action to implement a risk assessment and ensure that safety checks take place and that they are recorded.

The examples highlight that effective systems and processes had not been established or operated effectively to assess, monitor and improve the quality and safety of the service provided.

This was a breach of Regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that the registered person had failed to establish and operate effective systems and processes to assess, monitor and improve the quality and safety of the service provided. Furthermore, the registered person had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users who may be at risk from the carrying on of the regulated activity.

Periodic monitoring of the standard of care provided was undertaken by Warrington Borough Council's Care Quality and Contracts Teams. Heath Lodge last received a visit from the Care Quality Team in November 2015 which did not result in the need for a remedial action plan and a contract monitoring visit in July 2017.

We asked staff whether the manager was approachable and fair. Comments included "Yes, he is really good", "Yes" and "Yes, absolutely". We asked about staff morale and staff said "Really good, everyone has a good bond" and "Very fortunate because supporting each other, morale really good". However one said they felt morale was "up and down". Staff said they felt listened to and were able to make suggestions and we saw that there was a staff recognition scheme in place.

We asked whether service users had been asked to provide feedback on the quality of their experience. We saw that questionnaires were distributed and that service user meetings were held. The registered manager informed us that these had been chaired by service users but that, more recently, had been carried out 1:1 which were proving more successful.

We checked a number of test and/or maintenance records including: electrical wiring; fire alarm system; fire extinguishers; gas safety; water and portable appliances and found all to be in order.

Immediately following the second day of inspection the provider put in place alternative arrangements for day to day management of Heath Lodge pending the outcome of an internal investigation. In addition alternative staffing arrangements were implemented in response to whistle-blowing allegations received by the inspector during and subsequently to the inspection visits. The nominated individual submitted an action plan and has provided on-going updates.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to inform the Care Quality Commission without delay about incidents which occurred whilst services were being provided in the carrying or of a regulated activity.

The enforcement action we took:

We used our enforcement powers to issue a Fixed Penalty Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person failed to provide person centred care.

The enforcement action we took:

We used our enforcement powers to cancel the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not act within the principles of the Mental Capacity Act 2005.

The enforcement action we took:

We used our enforcement powers to cancel the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person failed to provide safe care and treatment.

The enforcement action we took:

We used our enforcement powers to cancel the manager's registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person failed to establish and operate effectively systems and processes to prevent abuse of service users.

The enforcement action we took:

We used our enforcement powers to cancel the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person had not established or operated effectively systems and processes to identify, receive, record handle and respond to complaints.

The enforcement action we took:

We used our enforcement powers to cancel the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person failed to establish and operate effective systems and processes to assess, monitor and improve the quality and safety of the service provided. Furthermore, the registered person had failed to assess, monitor and mitigate the risks relating to health, safety and welfare of service users who may be at risk from the carrying on of regulated activity.

The enforcement action we took:

We used our enforcement powers to cancel the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person failed to follow safe recruitment procedures to ensure fit and proper persons were employed.

The enforcement action we took:

We used our enforcement powers to cancel the manager's registration.